Region VIII- Pre-Summit for Healthcare
University of Louisiana at Monroe
February 18, 2004

Executive Summary

Overview

Over 300 participants from throughout northeast Louisiana attended the pre-summit. These participants represented all the various healthcare sectors and all twelve parishes identified as Region VIII. Dr. James Cofer, President, ULM opened the meeting outlining the Governor's request and charging the group to ensure that the needs and assets of northeast Louisiana were understood by our representatives in Baton Rouge. Dr. Eric Baumgartner, Louisiana Public Health Institute, served as the facilitator of the process. Linda Holyfield, CEO, P&S Surgical Hospital and past-chairman of the Louisiana Turning Point Public Health Improvement Plan, presented an overview of the health issues/statistics/challenges related to the Region VIII population.

The participants were organized into six break-out groups: uninsured, children, elderly, mental health/substance abuse, development disabilities, and hospitals. Groups were asked to discuss (1) the status of the issue/gaps, (2) Current strengths and assets available in the region, (3) potential solutions, and (4) priority requests of the state for that issue. Group facilitators were provided by the University of Louisiana at Monroe, the Children's Coalition of Northeast Louisiana, the United Way of Northeast Louisiana, North Louisiana AHEC, and the Northeast Louisiana Physician's Hospital Organization.

Each group facilitator reported out their findings to the larger assembly. In addition, over 200 individuals submitted written suggestions, comments, concerns, etc.

The following summary describes the results of this meeting:

I. Challenges posed in the community from the uninsured, Medicaid, Medicare and privately insured populations. What are the healthcare needs of children, the elderly, people with developmental disabilities, and people with addictive disorders)?

<u>Unisured/Underinsured</u>

- Limited access to care (all levels).
- Use of emergency rooms for primary care service.
- Limited access to prescriptions and other medical supplies (affordability and issue).
- Lack of access for vision/dental services.
- Most uninsured individuals work for small employers, without benefits. Unable to leave work (if they leave, loss of income, etc.).
- Lack of transportation in rural areas.

Medicaid Population

- Lack of providers willing to take Medicaid.
- Lack of clinic services with expanded hours.
- Transportation challenges, especially in rural areas.
- Lack of dental care & vision care.
- Limited # of school-based health clinics; lack of school nurses.
- Need to streamline the PCP system and ensure that there is a continuum between primary care providers and acute care services.

Medicare Population

- High cost of prescriptions
- Limited transportation for essential services (doctor's office, grocery store, etc.).
- Limited access to home-based and community-based services (especially in the rural areas)
- Limited access to health information sources (i.e. directory of available services).
- Limited nutrition services (over 50% of all elderly admitted to hospitals/nursing homes are mal-nourished).
- Limited access to affordable dental, vision, and hearing services
- Need for preventive care
- Need for single point of entry to access services for seniors.
- Limited access to mental health services for the elderly.
- More choice for supplemental insurance policies that are cost effective.

Privately Insured Population

- Lack of fully insured carriers available in the market
- Quickly moving towards a single-payor state (BC/BS)
- Premium cost increases, while reimbursement decreases.
- Incentives for small employers to offer health insurance are minimal.
- Lack of education of plan members regarding the access of appropriate health care.

People with Developmental Disabilities

- The costs of services prohibit even those that are otherwise financially secure to afford privately what is needed on a long-term, sustained basis.
- Home and community based services are not available in a timely fashion (waiting period approximately nine years).
- Low reimbursement rates.
- Limited physicians willing to take Medicaid.
- Bureaucratic processes are extremely convoluted and result in delays in service, frustrating layers and redundancy for consumers, user unfriendly, etc.

- Limited number of professionals who specialize in the area of pediatrics/developmental disabilities.
- Lack of transportation, especially in rural areas.

Mental Health/Substance Abuse

- Homelessness.
- Absence of medical detox facilities.
- Need more intervention and prevention for juveniles.
- Lack of access to psychological care for substance abusers.
- Service providers i.e., police and sheriff's departments need to understand mental health and substance abuse issues.
- Need more preventive education in schools for mental health and substance abuse
- Need more in and out-patient facilities and better coverage available for mental health and substance abuse services (these services are carved out of most medical plans).

Children

- Lack of parenting skills and involvement (lack of education, fear of the system).
- Limited transportation, especially in rural areas.
- Lack of providers willing to take Medicaid.
- Need streamlining of the PCP system; improved communication between PCP providers and other disciplines/providers.
- Need a strategic health care plan for children.
- Overuse of emergency rooms for primary care. Need more after-hours clinics.
- Lack of childcare for ill children.

Sustaining Hospitals

- Workforce shortages are limiting ability to serve population.
- Service shortages i.e. tele-radiology in rural areas.
- Lack of skilled beds for higher needs patients.
- Access disparity.
- Absence of health planning among private/public acute care providers.
- Duplication of expensive hospital services
- Need to address medical specialty coverage and call issues between facilities.
- ER overcrowding; ER diversions.
- Reimbursement is poor. Especially with Medicaid.

I. Strengths of Community Health System in Region VIII

- Adequate impatient beds and hospital diagnostic services to meet the needs of the community/region.
- In most cases, adequate number of physician specialists.
- Rural hospitals available in surrounding areas to provide basic services to the rural population.
- Joint ventures between physicians and hospitals to provide adequate inpatient and outpatient services
- Public health care system: LSU/EAC
- Public Health Units in every parish
- Four school-based health clinics.
- Large amount of outreach and LaCHIP enrollment has been accomplished.
- Significant prevention activities have been funded by Office of Addictive Disorders.
- Strong, collaborative professional and volunteer leadership (in all sectors).
- Strong training programs for health professionals in the regional universities.
- Adequate number of local hospitals with geriatric services.
- St. Vincent de Paul Community Pharmacy (low cost/no cost prescriptions).
- Number and availability of home health services.
- Number of long-term care facilities in the region.
- Councils on Aging.
- Wide array of choices for developmental disability consumers (large residential, community-based services such as community homes, individualized supports, sheltered work, supported work, respite for families, etc.).
- NOW waiver.
- There is community acceptance and support of persons with disabilities.
- Some local health coalitions (i.e., the Richland Health Coalition) have formed in an attempt to address local health issues collaboratively.

III. Important Gaps in the Community's Health System.

- Lack of planning among participants, providers in any of the sectors (acute care, mental health/substance abuse/ elderly services, children's health, care for the developmentally disabled, etc.).
- Inadequate number of after hours clinics for adults and children.
- Need for more primary care providers; need for some specialists (i.e. neurologists; radiologist coverage for some rural hospitals).
- Need dental insurance that is affordable.
- Need affordable pharmaceuticals.
- Lack of preventive health and health education in schools.
- Lack of dental care.
- Limited # of school-based health center, FQHC's, CHC's, etc.

- Lack of affordable assisted living facilities.
- Lack of adult day care.
- Absence of medical detox facilities.
- Lack of in-patient psychiatric beds, especially for adolescents.
- Lack of specialized day care for children with developmental disabilities.

IV. Changes That Could be Implemented to Improve the Healthcare of Region VIII (including potential funding sources).

A. Develop a transportation system that builds on existing assets, (i.e. vans owned by Councils on Aging, Nursing Homes, ambulances when not used for emergencies, church vans, etc.).
   - Grant support
   - Fee for service based on income
   - Government subsidy or dedicated taxes

B. Develop public/private regional planning councils in various sectors (i.e. acute care, mental health/substance abuse; caring for people with disabilities, etc.)
   - Consider creating Region VIII hospital district.
   - All healthcare is local.
   - Enhance collaborative efforts to work together.
   - Consider a regional certificate of need process.
   - Could be funded by provider tax, TANF?

C. Improve the education of the public in regard to various health issues
   - Reinstate health education, physical education back into the schools (elementary & secondary education).
   - Increase public awareness of core health issues, i.e. obesity, smoking, substance abuse, safety, etc. (possible grant funding or some reallocation of Tobacco monies; consider additional taxes on alcohol and tobacco products).

D. Address the professional health care workforce issues
   - Ensure that the universities, community college, technical schools receive adequate funding for health science/professional training programs.

E. Improve access to care (in all sectors)
   - Encourage physicians and public clinics to offer extended hours, when appropriate to alleviate ER visits.
   - Encourage insurance companies/employers to educate plan members regarding appropriate access of the health care system and how to interpret their benefits.
   - Encourage/demand better coordination between specialty care (Ouachita Parish) and rural health providers.

- Consider "one-stop-shop" approach and simplification of enrollment processes for access to services/coverage, etc. (elderly, children, mental health/substance abuse, etc.).
- Develop additional FQHC's, CHC's, school-based health centers, etc. Grant funding and reimbursement should cover majority of costs.

F. Establish a comprehensive directory that details healthcare resources (all sectors) in each parish.
   - Consider building on existing community resource directories, i.e. United Way's Directory, Children's Coalition, homeless coalition information, CABLE resources, etc.
   - Support the implementation of a local 211 system and make sure that health care resources are included. (Telephone surcharge similar to 911 surcharge).

G. Assure administrative efficiency.
   - Simplify user/provider processes for eligibility, planning, service approval, and billing.
   - Develop private/public partnerships.
   - Consolidation and coordination of regulatory activities (eligibility, monitoring, etc.)
   - Strengthen standards of participation. Encourage accreditation as a substitute for state's monitoring programs.

H. Address reimbursement issues, particularly with Medicaid
   - Dollars should follow the patients.
   - Public and private hospitals should e reimbursed the same for the same services.
   - Ensure that federal matches are maximized.

VI. Recommendations for State Health Care Spending Priorities

A. Require Regional Health Planning (all sectors)
B. Continue to subsidize the state hospital system until regional plan can be developed and implemented.
C. Address reimbursement issues. Medicaid reimbursement for providers of services should be enhanced.
D. Fund additional school-based health centers.
E. Demand simplification and streamlining of administrative processes and systems. Redirect savings into direct care delivery.
F. Work to attract additional class A insurers to the state.
G. Explore the use of provider fees (i.e. for waivered services). Consider eliminating the Homestead exemption and dedicate funds to health care delivery. Consider additional taxes on alcohol and tobacco.
H. Ensure adequate funding for higher education programs that produce health care professionals.

Region VIII - Child Health Issues

Challenges:

- Lack of parenting skills and involvement
  - -Lack of education
  - -Fear of the system
- Transportation, especially in rural areas
- Lack of Providers willing to take Medicaid
  - -LaCHIP
  - -Providers do not understand system
  - -Need more providers in rural areas
  - -Need expanded clinic hours (Loss of working time)
- No childcare for ill children
- High cost of prescription drugs

Needs

- More after hours clinics
- More school based clinics
- More back-ups to DCP
- More cooperation between PCP and providers
- Streamlining of PCP system
- Improved communication between PCP and other disciplines/providers
- Comprehensive educational process
- More parental accountability
- Consistent access to remove barriers whenever possible
- More grant writers
- Statewide strategic health care plan for children
- Identify barriers in Medicaid for transportation

Gaps:

- Lack of links in providers office (rural providers)
- Immunizations in middle schools
- Lack of preventative health education in schools
- Lack of dental care
- Limited # of school based health clinics
- Lack of school nurses
- Research – effective versus non-effective practices

Assets:

- Health units in every parish
- School based health clinics (4)

- LaCHIP and outreach that has been done
- Office of Addictive Disorders (significant prevention activities)
- Volunteerism
- Office of Mental Health
- LSU/EA Conway
- Medicaid website
- Children's Coalition of Northeast Louisiana
- AHEC/Early Start/Parenting Programs
- Home visitation
- Health fairs
- United Ways
- Universities
- Technical schools
- Community College
- Faith based communities
- FQHC
- Parish coalitions
- Media

Solutions

- More funding school based health clinics
- Increase economics in this area
- Regional coalitions to continue to work together
- Mandated education with LaCHIP
- More funding to lower high-risk behavior
- Need data showing the models work
- Revisit systems that are in place for effectiveness
- Address transportation issues in every parish
- Simplify prior authorization for DME's
- Simplify all paperwork
- More referral sources
- Widespread healthcare education
- More personal responsibility
- Federal and sate media campaigns
- Promote healthy lifestyle
- Raise taxation on alcohol tobacco for educational and health care programs
- Assure adequate funding for education and health
- Protect present resources while working on improvements
- More hospital/school partnerships
- Incentives to return equipment that includes lowered Medicaid benefits
- Increase private funding
- More FQHC's to lower ER burden
- Collaboration, communication, dissemination; Web resources

- More wide spread Community Care for providers and patients
- Scholarship incentives to increase physician extenders

Region VIII- Developmental Disabilities

Challenges

- The large number of individuals requiring Medicaid in the general population impacts the dollars available to those, who due to disability, are unable to earn enough to afford private insurance or pay outright for services.
- The cost of services prohibits even those that are otherwise financially secure to afford privately what is needed on a long term, sustained basis.
- The number of providers (doctors, therapist, etc.) of primary health care willing to take Medicaid rates is too low to accommodate the large number of patients.
- Those who work to support persons with disabilities (developmental, traumatic, age related, etc.) are not paid enough to afford private insurance.
- Providers of services to the developmentally disabled are not paid enough to provide health coverage to their employees.
- Home and community based services are not available in a timely fashion (waiting period is about nine years for the Home and Community Based Waiver).
- Reimbursement rates for service provision are typically so low as to not promote good business practices.
- Bureaucratic practices are extremely convoluted and result in delays of service, frustrating layers redundancy for consumers, fragmented and disjointed services that focus on process and not outcomes, a tedious, confusing, user unfriendly, and service delaying process for assuring consumer rights and prior approval for payments (Early Steps, HCBS Waiver, etc.)
- Community capacity necessary to close the front doors of the larger developmental centers has not been developed on a scale large enough to accomplish this without denying someone a service that can provided there (behavioral challenges, etc.).

Health Care Needs

- Primary care (physicians, therapists who specialize in the area of pediatrics or developmental disability, etc.)
- Home and community based services.
- For those living in community homes (ICFs/MR), additional leave days. The official state holidays should not count as leave days.
- Timely access to home and community based services.
- Quality vs. quantity of services. In several instances, the state has rushed to provide services to be in compliance with a time line, and has not developed standards of quality to assure that what they are buying is provided in an effective

manner or by persons or agencies that have credibility, etc. (Early Steps, PCS services, etc.).
- Simplification. Systems that focus on true quality outcomes instead of creating ominous paper trails that bog the system and rob the human and financial resources that should be directed toward consumers.

Additional Needs (Gaps)

- Adult day care.
- Specialized day care for children.
- Transportation, especially in rural areas.
- Single point of entry (each service component has its own eligibility process. Most persons need many different components of DHH and DSS services as well as Medicaid and Social Security, and have to jump through redundant hoops to acquire even the basic service. This is costly in terms of the individual's and the state's resources).

Strengths of Local Area

- There is a wide array of choices for consumers (large residential, community based services such as community homes, individualized supports, sheltered work, supported work, respite for families, family subsidies, and family-to-family support. These are developed according to the natural supports of the area (rural vs. urban).
- NOW waiver
- There is community acceptance and support of persons with disabilities.

Solutions/Improvements

- Consolidation and coordination of regulatory activities (eligibility, regulating, monitoring).
- Strengthen standards of participation. Encourage accreditation by nationally recognized entities (CARF, The Council, etc.) and reduce state's monitoring of the programs. Assure that those that provide the services have the financial capacity and service knowledge and skills needed to perform with quality.
- Assure administrative efficiency. Reorganize administration to eliminate redundancy and thereby reduce administrative overhead and simplify operations. Like operations should be grouped together.
- SIMPLIFY user processes for eligibility, planning, service approval, and billing.
- Review the regional offices with intent to determine the effectiveness and necessity of those offices.
- Develop private and public partnerships. Make state resources (training, etc.) available to private sector, develop community options for those whose needs are more challenging than typically met in community settings (behavioral, extraordinary medical, etc.), and request help from families with children in developmental centers to design and develop local programs that would meet the needs of their children.
- Redirect savings from the administrative efficiency efforts to improve rates for direct services provided by agencies that have achieved national accreditation.

- Require and fund a satisfactory living wage for direct care professionals (parity with state operated facilities).
- Fund and require Medicaid based ICFs/MR , Waivers, and State Plan services to include health insurance to employees as a part of their operation. This will redirect funding of health care for direct support professionals (uninsured working poor) who currently use state facilities (LSU Med) for their primary health care.
- Close front door of larger facilities as community options are made available.
- Explore the use of a provider fee for Waivered services to generate funding for additional Home and Community Based Waiver slots (a $40 million potential).
- Include small ICFs/MR in the definition of home and community based services.

Prioritization

- Reorganize state administrative activities to achieve efficiency and cost savings.
- Simplify processes to provide immediate relief and best use of existing resources.
- Adequately fund services for children, the elderly, and persons with developmental disabilities. Include requirements for adequate wage and benefits for the direct support professionals.
- Have a neutral party determine who wants what services and study the most resource effective manner in which to deliver these (regional planning?)
- Develop well paying/benefits attached human service delivery jobs so as to reduce the actual number of people in the general population requiring Medicaid or other state assistance for their health care. Similarly, maximize the use of Medicaid funds for those who are not able to use private sources to fund their health care so as not to use valuable state dollars unnecessarily.

Region VIII - Seniors and Long-Term Care

Strengths of our Community

- Number of local hospitals with geriatric services
  - St. Patrick's Geriatric Specialty Hospital
  - North Monroe Medical Center Geriatric Psychiatric Unit and Transitions Unit
  - Multiple Hospital Outpatient treatment programs around region
  - Multiple health care facilities targeted toward providing care to older adults
- St. Vincent De Paul Community Pharmacy
- Number and availability of home health services
- Number of long-term care facilities in region
- Location of Universities in Region -ULM, Tech, Grambling. For example, ULM Pharmacy, Occupational Therapy, Kinesiology, Gerontology, Speech and Audiology, Dental Hygiene, Nursing, etc work within the community health care settings and can possibly expand their role.

- Provide education to health care providers in region on providing care and services to an aging population. The University of Louisiana at Monroe has a very strong Health Sciences component and a very strong Gerontology program, both ideally situated to provide this training. ULM Gerontology has developed the M.A. Degree online and currently provides education to professionals in Louisiana, Mississippi and Texas this service can be expanded to the direct service agency throughout the rest of Louisiana. The University and the Gerontology program are currently capable of providing training the region and state through distance education technologies geared specifically toward those currently working full time. Additionally, there are no geographic barriers as the education would/could be offered online.
- Councils on Aging

Challenges, Needs and Gaps

Long Term Care - Problems and possible solutions

- Funding -LA ranks lowest in funding of LTC
    - Increase Medicaid funding for LTC to at least regional average, provide economic incentives to facilities that are well run; provide leadership/guidance to those who lag behind. Penalizing and shutting down facilities should be considered a last resort, as it is the elderly person who suffers in the end.
- Educate consumers on LTC Insurance through media campaign
- Affordability – Prices are currently out of reach for most seniors, this is why the majority of funding comes from Medicaid in LA
    - State should provide some incentive to individuals who purchase LTC insurance. Examine feasibility of funding through tax relief majority of insurance cost for elderly (would it cost less than we currently spend on Medicaid funded LTC). Examine other options encourage individuals to buy LTC insurance and competition within industry. Ensure that any policies sold are sufficient for the care needed (state average cost and COLA)
- Reimbursement – Rates are very low providing barriers to providing LTC as well as improving quality (currently required to do more with less)
    - Increase Medicaid funding for LTC to at least regional average
    - Those that meet minimum standards for care should be compensated
- Liability/malpractice insurance – rising insurance costs are being passed down to consumers; these costs are deterring physicians from providing care in this setting and proving to be barriers for entry into LTC.
    - Tort reform is needed. Lawsuits increase the cost to not only to run a facility, but are also a barrier to the development of newer facilities. These costs are passed down to consumers. Rising malpractice rates are becoming a barrier to many areas throughout the country for physicians to provide care and should be examined here as well.
    - Ceiling/cap of monetary awards for lawsuits.
    - Involve Insurance commissioner in discussion of lawsuits and tort reform

- Education – many in LTC have little gerontology education in caring for the elderly and working with the various state and federal agencies, summit participants stated that more education is needed for all major staff to help provide care for the elderly in these facilities
    - Louisiana has one of the lowest requirements for long-term care administrators (Nursing home and Assisted Living) – consider raising minimum educational requirements to include gerontology training as well as degree
    - Throughout the session, individuals stated the lack of training that care providers (nurses, physicians, social workers, etc) received either in school or on the job is a problem which hampered their ability to provide quality care (and possibly lower cost care). We should take advantage of the resources provided in our region to offer training to individuals working with the aged. One example – ULM Gerontology M.A. and undergraduate program is available online and is currently providing distance education in gerontology throughout the state and region (Texas, Mississippi, North and South Louisiana) in Gerontology and Geriatrics. We should utilize existing infrastructure and intellectual property to educate those in the aging field.
    - Examine feasibility of economic incentives for individuals to pursue additional gerontological training or education. Funding possibly could come from a portion of Medicaid or Medicare dollars
    - Also State should examine who primarily pay for senior care (other than the state) and explore possibility of underwriting costs e.g.: other insurances companies
    - Student Loan repayment for practicing in LA.
- Staffing Problems, Nurses, Physicians, Social Workers, LTC Administrators, CNA's, etc
    - Throughout northeast Louisiana, there is a lack of adequately trained professionals to care for seniors. There is also a staffing shortage in the health care field. State and Federal government should provide incentives for individuals to pursue careers in aging. For example, Medicare pays for the majority of Medical School Training, yet only very small minorities are pursuing Geriatrics. Some states are paying for promising individuals to pursue and practice medicine - this could be explored and utilized esp. in rural underserved areas.
    - In Louisiana and nationally, there is projected a 40% shortage in trained LTC administrators (nursing home and assisted living). We need more education and training in LTC as well as recruitment into the field. For example: Do we want someone with only 2 years of college running a major long term care facility caring for your grandmother or mother?
- Need for Specialized Dementia Care (for home that currently run 60% plus in resident mix)
    - Set minimum standards for dementia care for dementia wings
    - When standards are met, provide economic incentives
- Recruitment/Retention Issues in LTC settings

Access to Home and Community-Based Care - Problems and possible solutions

- Medicaid and Medicare dollars are too scarce/limited
    - Medicare pays for little (if any home and community based care), Medicaid pays for more, but is insufficient. Currently it is easier to get Medicaid to pay for care in a nursing home care than home care. This needs to be re-examined. Many individuals do not need LTC, just supportive care that can be done in the community.
    - More Olmstead alternatives – Louisiana has very few alternatives to the Nursing Home model of LTC.
    - Lack of Adult Day Care programs (none in Region VIII). Provide Pro-rated costs and fees based on income and services. Minimum standards need to be applied (particularly related to dementia care). Include more activities for seniors (TV is not an activity).
    - Other than medical care (Home Health) there are little or no supportive services to help seniors remain in their homes, those that are funded are through Medicaid Elderly waiver and too few. The elderly waiver program needs to be re-examined. If it is not being used, why. Dedicate state funds to this program and others that provide home based care. Possibly utilize existing services in communities to provide these services
    - Utilize high tech Assistive Technologies for provide and maintaining the elderly in their homes. LTC costs are averaging $40K a year, it is more cost-effective to keep the elderly in the home, even if the home needs some modifications
    - The Councils on Aging (area agencies on aging) provide some supportive services – increase funding to these programs. Provide more options (lawn service, handyman, home modifications, meals preparations, laundry, etc).
    - Encourage creative uses of existing LTC facility services. For example, Nursing homes already prepare meals, provide laundry service, maintenance, nursing, CNA and transportation. Expand these services to the community. This can also relieve some of the stress with a future move to LTC.

Medicaid Program- Problems and possible solutions

- Across the board, Medicaid was discussed as a problem, either with regard to waivers, elderly waivers, reimbursements, funding, regulations, the types or limitations of care allowed, number of prescription drugs, etc.
    - It seem apparent that the Medicaid system needs to be reexamined to determine if it is providing a barrier for seniors to seek and receive health care
    - Are dually eligible seniors (those who qualify for Medicare and Medicaid) really being served by Medicaid? With the limitations and regulations is it worth developing a specialized program for seniors (SeniorAid) that can address the needs of LTC, Home care, daycare, prescriptions, OTC drugs, etc. ?

- Remove and redistribute Medicaid certificate of needs for chronically empty beds in LA to areas of high need

Access to Information (Health Sources) - Problems and possible solutions

- A problem across the spectrum of providers – Providers and seniors need access to timely relevant health information and services; agencies need to know what other programs and services are available; physicians and health care providers need to know what is available as well
  - Need to collaborate and coordinate health information, programs and services referral system in LA. – We have small I&R programs (C.A.B.L.E.), Councils on Aging, etc. But all are local.
  - State Wide Information Center for elderly services
  - State wide 2-1-1 is an option
  - Include pharmacist and other resources seniors tend to frequent as I&R providers
  - Utilize technology (Medline plus), in community to provide needed healthy information seniors want a need.
  - Targeted Health Information – either via the internet, physician visits, PSA's, dental and vision clinics, etc. Information has to be timely and relevant to older adults. Funding unsure – Department of Public Health?

Shortage of Services and Facilities in Rural Areas

- In rural areas, there are limited health care facilities or personnel
  - Visiting providers need facilities in which to provide care
  - Need for "clinics" or roving clinics.
  - Encourage physicians to make Home visits (economic reimbursement)

Underfunding and affordability of Assisted Living Facilities

- Need for low-income facilities and expanded availability
  - Some states (Texas and Arkansas) are funding assisted living with Medicaid/Medicare dollars
  - Utilize existing vacant buildings to create assisted living facilities (Schools, nursing homes, hotels, etc)
  - Create incentives to locate in inner city buildings to help revitalize downtown areas.
  - Seek out federal housing funds to target inner city and poor areas.
  - Encourage partnerships between low-income senior housing and home health agencies to provide quasi assisted living services at low cost.

Transportation Issues

- No real public transportation for elderly. In Monroe, for example, when it is available, the public transportation rarely goes to grocery stores, pharmacies, physician's offices and tends to not go where seniors generally need to go –grocery store, doctor's office, pharmacy. West Monroe and surrounding parishes have NO public transportation

- There are even fewer social transportation alternatives (council of aging, senior centers, mall, movie theaters—all activities that help to maintain the physical and mental health of the elderly (especially at night).
- Create incentives for cities to provide senior transportation services
- Currently only the Councils on Aging provided specialized medical transportation to the aged –this program can be expanded
- Utilize existing transportation options (like those provided by many LTC facilities who already do transportation) to provide local community and medical transportation
- Consider transportation vouchers

Pharmaceutical drug access and funding

- Many seniors do not have "gap" policies or employers to pay for drugs; Medicare will not go into effect for 2 more years; many will still bear the brunt of the costs – remember high poverty, low literacy, high minority populations
  - Examine possibility of State to negotiate prescription drug costs for seniors
  - Encourage physicians to prescribe cheaper generic alternative drugs
  - Develop automatic system for physicians to identify effective low cost drugs as well as make it mandatory that pharmacists question or recommend lower cost alternatives
  - Expand drug discount card sign up programs
  - User friendly, timely Medicaid drug payment information for physicians
  - More emphasis in medication compliance and use – Illiteracy is a especially a problem in NELA.
  - Should the state expand or delve into the issue of foreign drug importation or attempt to negotiate drug costs for senior adults with pharmaceutical companies

Nutrition Services

- Food is essential to maintaining good health – over half of all elderly admitted to hospitals and nursing homes are in a state of malnutrition. Malnutrition is also related to dementia and misdiagnosed.
  - Food insecurity is a major problem; other than the local food banks which are operated through local fundraising; and the limited funding provided by the Older Americans Act; what role should the state play in providing proper nutrition.?
  - Expand Food Bank programs for qualified seniors to receive free food each month
  - It is estimated by the American Dietetic Association that for every dollar spend on nutrition, three are saved in health care costs. State should examine it's role in assisting seniors to make proper food choices
  - Tax free shopping days for seniors
  - Senior discount shopping cards (similar to those used by major grocery chains today).
  - Availability of free nutritional counseling (could be part of health information referral mentioned above.

- Allow other food producing entities (LTC facilities, restaurants, etc) in rural areas not served by senior meal sites provide home delivered meals
- Model programs in Louisiana for in home food delivery (Peapod, etc). For example, order groceries online and have store provide delivery – Boston, New York, San Francisco, all provide similar services.
- Involve churches and other religious organization in food delivery. Churches are in more rural areas – investigate use of the "Faith Based Initiative" – home delivered foods, etc.
- Supplement meals programs by AAA with Concurrent State Nutrition Funding

<u>Dental, Vision and Hearing Care and Access</u>

- Medicare pays for extreme care such as surgeries, but for basic preventative care (eyeglasses, tooth cleaning, hearing aids it does not pay – unsure about dually eligible)
  - Allow Medicaid to pay for eye glasses for elderly
  - Allow state to negotiate dental/vision/hearing costs for seniors (similar to the way insurances companies negotiate reimbursement rates for services.
  - Discount card
  - Coordination of services Medical, dental, vision, hearing, etc in a single point of entry.
  - Public private partnership for connecting resources (like the lions club eyeglass programs)

<u>Need for preventative Health Care</u>

- Little emphasis is placed on preventative health, more reactive versus proactive in health care
  - Promote the family physician as a resource for preventative health care
  - Provide programs for preventive health – through public health departments?
  - PSA's for preventative health? Free or low cost clinic for preventive health screenings
  - Geriatric Case Management and out reach coordination to identify candidates who for preventive health as well as target programs and services within the community Generally funded through state agencies on aging (LA = GOEA).

<u>Need for Single Point of Entry Health Care services for Seniors</u>

- Coordination of services – envision senior suites/"one-stop-shop" – building where SSA, Medicare, Medicaid, Physician, Dental and Vision are all in a "one stop shop" with transportation provided to and from.

<u>Special considerations for North Louisiana</u>

- We have to be careful to not just supply funds based on the "number of older persons" living a particular region but to take into account geographic cultural and demographic variables. It is much easier and more cost effective to provide "services" to a populous area than it is to provide the same services to a rural area. Additionally, we should think about targeting information and services to

particular populations that might otherwise be excluded. These include rural elderly, minorities, and those residing in impoverished areas.

- High rates of illiteracy (2nd in nation)
- High poverty (The Mississippi Delta is one of the poorest areas in the U.S.)
- A higher percentage of rural elderly, much aging in place in rural areas
- High minority population in cities and rural
- Minority diet puts these individuals at high risk for heart disease and diabetes
- North Louisiana in the "Stroke Belt"
- Remove Cultural barriers to health care access in NELA

<u>Need more Technology into Health Care Arena</u>

- Electronic Charting
  - Help eliminate medical misunderstandings, possible medication errors, and automatic drug interaction notification. Can also be useful for low cost drug identification and a reduction of paperwork and billing
  - Electronic Health Care Network linking hospitals, nursing homes, pharmacies, etc to help coordinate care and identify care needs

<u>Regional Planning between public, private, non-profit sectors</u>

- Semi-Annual Health Care Meetings with Department of Health and Hospitals to discuss issues similar to what was done with the regional health care summits to discuss needed changes when population changes

<u>Long-term care for the Prison population</u>

- An aging (and growing) prison population will cost more in the future to provide long-term care. There is a need in Louisiana for specialized long-term care facilities for this population as well – solutions this type of care need to be carefully studied

<u>Mental health care for the elderly</u>

- Senior access to mental healthcare is significantly impaired, while depression and dementia are common diagnoses of the elderly; both being conditions that deteriorate quality of life and physical health for seniors, and often times necessitate frequent hospital admissions and compound medical illness
  - Medicaid for psych care is hindered in the states Single Point of Entry (SPOE) program, which is a clearinghouse or gateway to state psych beds. A provider has to contact the SPOE for placement of a patient. The SPOE rarely provides support for basically 2 reasons: lack of psyche beds in state hospitals and the fact that the existing beds are any given day are 65% occupied by forensic patients.
  - The majority of private hospitals choose not to be Medicaid providers due to insufficient reimbursement. Currently the Medicaid daily reimbursement for in-patient psyche care is $344.85 while most providers operating cost per day is $800-$1,000.

- Separate Medicaid facilities for mentally ill. They should not be housed with normal senior adults or dementia residents

Grandparents raising grandchildren

- The number of grandparents with primary responsibilities is increasing
- Research shows that grandparents raising grandchildren have poorer health and higher rates of cardiac disease.

Other Possible Funding solutions

- Additional tax on items related to future increased health care costs – Alcohol, Tobacco, Gambling, Candy, High fat, low nutritional value foods
- Eliminate Homestead Exemption and use funds to provide essential services.
- State (Parish) funded senior services program- provide low cost vision, dental, preventative health, prescription drugs. Funding: Possibly an "opt out" portion of the property tax in each parish to be dedicated to "senior services." Areas where there are high number of elderly would generate more $ for services. Services would be "paid for" by the elderly so the stigma of a welfare program is eliminated. Some means testing would probably be needed.

Region VIII- Mental Health/Substance Abuse

Needs,/Challenges/Gaps

- Only 63 residential beds for adolescents in state
- Homelessness
- Absence of medical detox facilities
  - None available
  - 22 beds statewide
- Intervention needed before criminal activity
- Juvenile problems after incarceration and before
  - More intervention and prevention
- Mandates being met by figure heads
- Lack of halfway houses for substance abuse
  - There are none
  - Only 6 female beds in NE La
- No mental health halfway houses or lack of permanent housing
  - Only available in limited areas with assertive community treatment
- Co-occurring disorder services
- No multi-systematic therapy
- Unavailability of psychological care for substance abusers
- No geriatric substance abuse programs
- No parity for mental health and substance abuse insurance

- Service providers such as police and sheriff's department need to understand mental health and substance abuse issues
- More education in schools for mental health and substance abuse
    - Not everything is behavioral only
- Medicaid providers and access to immediate service takes months
    - You could die before you are seen

Solutions

- Educate
    - Model program after what Memphis Police have to deal with substance abuse and mental health
        - Use statewide
    - Coordinate DA's and judges so treatment is completed. Treatment needs must be met beyond what is mandated by courts
- Substance abuse assessments should be done before a non-qualified individual determines length of stay, treatment plans, etc.
- Implementation of clinical based and evidence- based programs that work and take into consideration continuity of care and best practices standards
- Judges should mandate assessment procedure and outpatient treatment following incarceration
- After-care is left out by the judicial system. Substance abuse and mental health services should be available in all jails.
    - Treatment in department of corrections
- Day treatment for mental health
    - Ages 21-65 No state supported day treatment
- Need discipline program in schools that is consistent and quickly done
- Education of MDs related to mental health or substance abuse
    - 50% of ER visits are related to this
- Recognition/referral needed for ER's, general practice, etc.
- Psychiatric ER's need to be developed to provide treatment related to problem
- Family services need to be offered
    - 70% of domestic disturbances are substance abuse
- Collaboration families, community health, and teachers for programs and services
- Proactive vs. Reactive
- Must have earlier diagnosis
    - Big dollar savings
    - Focus treatment
    - Managed care has pre-conceived ideas about how long healing process takes
- More providers, psychiatrists, and others
    - Need to use other personnel such as CSAC's
        - Northwestern is only program
- Residential treatment for mental health is needed

Needs for State Supported Strategies

- Better utilization of existing services
- Still need more comprehensive guides to services and wider distribution
- Mandate training for law enforcement to reduce lawsuits, etc.
    - More cost effective
- Broad based training to include teachers, judges, and professionals
- Change Medicaid rules to pay for residential treatment
- Support system of care principles and organization principles i.e.: networking
- Better share resources without combining services
    - Denial of faith-based organizations is not being broken down
- Program exists already
    - Model best practice
- State can support community based programs
- Parental involvement must be increased in schools
- Utilization of care algorithms

Region VIII – Sustaining Hospitals

Needs, Challenges, and Gaps

<u>Workforce shortages</u>

- Rural implications
- Economic development implications
- Ouachita Parish is a regional provider of specialty care (including for Southern Arkansas)

<u>Service Shortages</u>

- Tele-radiology
    - Rural
- Transportation of trauma patients
    - Rural
    - No trauma transportation
- Lack of skilled beds for high need patients
    - Long term care (Ventilator patients)
- Lack of mental health care facilities
- High cost and volume of trauma patients, pre-mature babies and more
- Access disparity

<u>Absence of Health Planning among Acute Care Sector</u>

- Specialty hospitals as competition
- Duplication of services/intense competition between private providers (in Ouachita Parish there are three open-heart programs; two PICU's, 13 MRI's, 4 hospitals with cath labs, etc.).

- Community over-bedded; local, large private hospital recently constructed two additional floors/30-40 additional beds.
- Medical specialty coverage and call issues between facilities (i.e., one surgeon on call in entire parish, wreck victims taken to three different hospitals and all needing a surgeon. Should have a back-up call system, or work with emergency providers to determine which hospital has their turn at caring for the trauma. Hospitals could take turns receiving the trauma, etc.)

Reimbursement Issues

- Private & public hospitals should be reimbursed the same for the same services; let the money follow the patient

Other

- Transfers for rural areas for higher levels of care
- Recruitment issues, Primary Care physicians, HR
- Over-utilization of ER = PC services
- J-1 program ineffective
- Capacity of facility
- ER diversions
- ER triage
- Trauma care network
- Critical Care implications
- Lack of LACHIP providers

Strengths

- Some recruitment services AIPSAs
- Abundance of health care training programs
- EACMC/Charity system
- OPH – Preventive care
- Low percentage of Managed care in region
- Excellent providers, programs, specialists, services, facilities, and HC professionals
- Legislative leadership strength, other coalitions, associations
- Technology
- Our challenges will have/force catalyst for change

Solutions

- Increase Medicaid reimbursement according to need
- Economic base = Tax base + Employment
- Regional planning AMG providers
  - Across private sector
- Funding for health care instructors
- Patient education/accountability
- Public education services available in region

- Evaluate policy conflicts
- New funding sources
- Reduction in regulation/paperwork
- TORT reform
- Emphasis on wellness vs. illness
    - Preventative care
    - Health education
- Nursing Home – Increase ability to provide services to more chronic patients
- Statewide trauma plan by type of injury
- Incentives
    - Provide employee health insurance
    - Use existing buildings/facilities rather than new
- Divert state gambling to health care
- Statewide psychiatric relief plan
- Hospital cost-cutting solutions
    - Reduce duplication of services
- Community Education on end of life care
- Obvious incentives to utilization not available to all providers
    - KidMed – WIC
- Coordination / evaluation of all programs
    - A system of regional evaluation by HC professionals
    - What drives patients?
    - What are implications?
- Computerized patient data/funding or dollar incentives comp/common system
- State legislature with experienced staff/Health Care background
- Encourage more grass roots participation in legislative process
- "Align incentives"
- State accountability for records, updates
    - State leadership role
- Medicaid data on "cards" carried by patients
- Re-evaluate Critical care
- More equitable distribution of health care monies to local communities
- Collaboration to keep services local if feasible
- "Outside" expertise
    - National best practices

Region VIII – The Uninsured

Needs, Challenges, and Gaps

I. Transportation

- Access to Care—especially for out of town services (e.g., specialized care)

- Bring to Care to Them—Mobile unit
- Federal Funded Transportation available – Matching Funds Too High

II. Prescription Drugs

- Affordability of prescription and non-prescription medications and supplies (i.e. diabetic supplies, wound supplies, etc.)
-
- Need to streamline what programs we have; Uniformity in Application

III. Other Medical Needs

- Lack of access for vision/dental services (e.g., extractions, eyeglasses, etc.)
- Lack of awareness of available screenings
- Utilization of the emergency rooms for primary care (lack of after-hours clinic services)
- Gap in OB care in some rural areas
- Lack of providers who accept Medicaid

IV. Education

- Children—School system – proper diet
- Preventative Education
- Educate Healthcare providers to identify the uninsured to target Senior Citizens
- What is an Emergency?? (ER/PCP)

<u>Regional Resource Guide (website)</u>

- E. A. Conway—Breast and Cervical Screenings
- Obstetrical Care—rural areas—attracting providers
- Dental and Vision—Screen
    - No provisions for Extractions, Glasses, etc.

SOLUTIONS

V. Transportation

- Van Service—LSU/Conway
- Federal funded transportation available—need matching funds
- Consider building on existing infrastructure, LSU, Council's on Aging, etc.

VI.

VII. Enhance Collaborative Effort to Work Together

- Incentives to stay in rural area
- Develop additional FQHC's/CHC's in communities (perhaps one per parish)
- Expand the availability of quality FQHC's and CHC's (including the 340B Pharmacy program).

VIII. Education

- Allied Health Services
- Funding Formula Rural
- Incentives to Educate and Network to Rural

- Obtain Research Dollars
- Health Service Resource Guide
- Continue T O P S
- Incentives to Work Rural Areas
- Better Funding Allied Health Colleges (Pharmacy/Dental Hygiene/Nursing, etc.)
- Tap into Appropriate Foundations for Funding (for Universities)
- National Health Corps
- Educate our Legislators on Need for Money
- Designate Separate Health Science Group
- Federal Grants available—Community Partnerships formed to take advantage of grants
- School based health system—availability

PRIORITIES

Core Public Health—Education, Prevention, and Screening

- Address ER use issue for Primary Care
- Begin prevention/health education in School System
- Address Poverty/12 parishes; create jobs

Education

- Address the health professional shortage issues. Expand the ability of professional training programs to graduate more health care professionals (e.g. improve the Funding Formula & finding money to hire professors/educators)—
  Address Higher Education and Technical
- Drop-Out Rate—Address Dual Education Program→College or Technical
- Research Money Available for Higher Education

Access to Care

- Coming to Care, Continuity of Care—Office visit, Testing, Prescriptions
- Directory for Region
- Improve the rate of reimbursement and allow Medicaid reimbursement to follow the patient
- Develop tax incentives so small business could afford health coverage for their employees
- Provide premium support based on income for

Looking for Community Partners

- Consider developing additional FQHC's or a look-alike's
- Need regional health care planning that includes private and public partners; make all parties have a responsibility to address community health care issues

- Consider developing health collaborative (i.e., the Richland Parish Health Collaborative—most grants require partnerships
- Address Emergency Room use for Primary Care
- Finding Solutions which do not cost money and utilize money we have more efficiently (i.e., reduction in duplication of diagnostic testing on patients seen in community clinic, then transferred to LSU/EAC-currently LSU/EAC repeat diagnostic instead of accepting the information from the initial provider)
- Support Local Events

<u>Resource Guide</u>

- Build on existing Resource Guides/website to include health care resources (i.e. add to the United Way's Community Resource Directory, support the development of a regional 211 system).